

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25206
STATE FILE NUMBER
Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 119

FILED JUL 30 1957

300
1-57

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Laclede	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lebanon Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 450 Michigan		Length of stay in lb —	d. STREET ADDRESS (If outside, give location) 450 Mich. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Martha Middle E Last Woody			4. DATE OF DEATH Month July Day 14 Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Johnstown Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Christopher Myers		13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE F. Marion Woody
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	17. INFORMANT Address Mrs. J. H. King Lebanon Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple intermittent cerebral emboli			INTERVAL BETWEEN ONSET AND DEATH 1 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) 332XF DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture right hip 2-20-57			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell at home.	
20c. TIME OF INJURY Hour — Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from June 24, 1949 to July 14, 1957 and last saw her alive on July 8, 1957 Death occurred at 1:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paula Jones md		22b. ADDRESS Knight Bldg. Lebanon Mo	
22c. DATE SIGNED 7/15/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/57	23c. NAME OF CEMETERY OR CREMATORY Lebanon
23d. LOCATION (City, town, or county) (State) Lebanon Mo.			
24. FUNERAL DIRECTOR ADDRESS S. R. Palmer Lebanon Mo		25. DATE RECD. BY LOCAL REG. 7-20-1957	26. REGISTRAR'S SIGNATURE Hella R. May

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Do not, however, enter information on any of these items unless it must be causally related.

Received 7-29-57

Laclede County Health Unit

File No. 419

Date Filed 7-29-57

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed S. P. Palmer

Licensed Embalmer No. 2204

P. O. Address Shannon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.